

**Commission to Study Mental &  
Behavioral Health**

**WRITTEN TESTIMONY – September 14 2021**

**Testimony to Maryland Commission to Study Mental Illness and Behavioral Health, Howard County  
Sept. 14, 2021 by Janet Edelman**

My name is Janet Edelman, I am the Chairperson of the Howard County Local Behavioral Health Advisory Board, a longtime member of NAMI and a family advocate for people living with a mental illness. I am speaking today as an individual.

First, I want to mention some of the things that are going well in Howard County. We are working on implementing a new regional crisis system, have just implemented LEAD for jail diversion, the school system has just expanded social workers to 20 additional schools. A new harm-reduction program was recently implemented and we have developed new educational programs. There is much work left to do.

Some large problems remain which are under the control of the state of Maryland. Optum's failure to pay Medicaid providers promptly have made it very difficult for providers. I cannot understand how after all of these years of managed care, the vetting process allowed Optum to be selected if they could not perform and that the BHA did not seem to have the tools to rectify the situation. I hope that someone makes sure that this is remedied the next time Maryland bids out for an ASO.

Concerning the Involuntary Commitment Stakeholders' Workgroup Report, I want to thank the Commission for studying this issue. I advocated, with others, for the change to the Maryland law in 2003 on the danger standard for emergency petitions. That change, along with the statewide training at the time, was not sufficient to significantly improve the danger standard in Maryland.

While the BHA proposal is an improvement, several weaknesses remain. Most concerning is that the proposal does not include psychiatric deterioration as a danger to self. I reviewed comments submitted by Brian Stettin of the Treatment Advocacy Center. Brian is an expert on this issue and his comments make a lot of sense to me.

The BHA proposal recognizes the need for improvement and clarification of the danger standard, and proposes extensive training on the new standard. I think that the inclusion of wording in the danger standard for someone who is unable to meet their basic needs is an important clarification.

The proposed changes do not go far enough. If you witness someone who is psychotic and has hallucinations and/or delusions that could affect their own well-being or those of someone else, it is imperative to step in to prevent harm. Many of the people in the commitment process do not have awareness of their illness as a direct result of their illness and cannot see their symptoms as a sign of disease. It does not take a psychiatrist to realize that someone, who for example, thinks his food is poisoned by the government, or who hears voices telling him to harm himself or others is a danger. As mentioned on page 10 of the report, there are several medical articles that describe deterioration of the brain as a result of untreated psychosis. This should certainly qualify as a danger to self.

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My brother has lived with schizophrenia and heard voices for over 50 years. He is an example of how people who are very ill, but medicated and with support, can live in the community successfully. For those whose illness does not allow them to accept help, Maryland allows them to deteriorate until they are so very ill that they may become homeless, in jail, cycle in and out of hospitals or be close to death. I believe that this is very wrong.

Thank you for giving me a chance to comment.

### **Comments on the Involuntary Commitment Stakeholders Workgroup Report of 8-11-21**

My name is Patricia Sollock, and the purpose of this communication is to comment on the Involuntary Commitment Stakeholders Workgroup Report of 8-11-2021 that I understand will be reviewed by the Commission to Study Mental and Behavioral Health in Maryland. I have lived and worked in Maryland for 41 years and practiced as a licensed mental health provider and MH Director of two detention facilities, certified by the National Commission on Correctional Health Care, with an average daily population of approximately 700-750 inmates. Additionally, I have been a consultant and trainer nationwide for various Corrections facilities, as well as provided consultation and training for the National Institute of Corrections, Federal Parole and Probation, and Federal Judicial Center. I have participated in Mental Health Commissions and presented on mental health topics at national conferences. I have numerous times testified on the irreversible negative impact that incarceration has on mentally ill persons, their families, and the community, and I have tirelessly advocated for humane treatment in professional settings, not jails. Throughout my years I have witnessed the pervasive criminalization of mental illness and use of jails as de-facto hospitals for this population. As an out-of-state consultant, I have learned about other mental health systems and became aware of Maryland's low ranking in facilitating commitment for individuals in the process of psychotic decompensation. Despite my experience and insights about the challenges that caretakers and providers face to prevent the incarceration of patients with mental illness, I submit these comments on my behalf and not on behalf of any institution or organization that I am or have been affiliated with.

Outpatient and correctional mental health providers, as well as community first responders, or caretakers, all relay frustration about their hands being tied when trying to access treatment and prevent negative outcome for persons psychiatrically decompensating in the community. The current "danger standard" is a barrier to needed hospital treatment and once incarcerated and sentenced, patients are no longer eligible for Court ordered evaluations. Those who refuse treatment continue to deteriorate and create major management problems for Administrators Correctional Officers and providers and because jails are not hospitals and thus restrictive housing is oftentimes the only way to ensure their safety and that of others. Even if two providers file certifications for hospitalization, this is the population that MDH has categorized as last priority for admission regardless of degree of impairment. This is because there are fines attached to delayed Court ordered evaluations while there are no penalties for not honoring physicians' certifications. This creates a terrible situation where hospital admissions are prompted by avoidance of penalty fees, rather than by patient need. The result is that some patients are likely to be released much more ill, less likely to respond to medication, more dangerous than when they entered jail, and even more likely to commit another crime that could also be more serious than previous ones. Outpatient programs may reject patients due their chronic involvement with the criminal justice system and/or history of non-adherence to treatment. This is the perfect storm for creating a criminal justice revolving door for mentally ill persons while their options for treatment and self-sufficiency are further reduced. Allowing a psychotic person to arrive at such point of decompensation that his behavior results in incarceration, is callously disregarding the downward course of untreated psychotic decompensation, especially when the symptoms and performance indicate a deterioration of functioning known or believed to be leading to critical levels by any reasonable person. Sadly, the feared negative incarceration outcome, may result from misdemeanor offenses, although in some cases from very regrettable and tragic crimes such as murder of caretakers or innocent persons in the community that forever affect the patient, their families, and the community at large. Not surprisingly, oftentimes the public is astonished to learn after a tragic event affecting

more than just the patient, that the patient's caretakers had unsuccessfully exhausted all means to seek in-patient treatment but that the patient did not allegedly meet the current danger standard. The current 'danger' standard focuses on obvious (overt) danger to self or others yet disregards the documented dangers of 'covert' brain damage that progressively deteriorates due to chronic psychotic episodes, especially if untreated.

For years I have witnessed how we penalize patients for decompensating and for committing crimes while their judgment is impaired by delusions that torment them, but we do not admit responsibility for placing obstacles to treatment when they are in the process of decompensating at which time treatment is essential.

Recommendation:

For all the reasons presented and to try to halt the pervasive criminalization of persons with mental illness, *I recommend the following:*

**1. The inclusion of "psychiatric deterioration" in the current danger standard.**

Note: the current danger standard only focuses on physical/medical deterioration and dismisses documented progressive brain deterioration in untreated psychosis reducing the life expectancy of persons with mental illness by 10-20 years.

**2. The standard must clearly be defined and include**

- a. individual's personal and psychiatric history, if available**
- b. individual's level of performance deemed by any reasonable person to be heading to a deteriorating and dangerous course**
- c. specific clarification that danger is reasonably expected and need not be imminent.**
- d. danger to self as evidenced by deterioration of brain function or by physical deterioration due to psychosis.**

I believe it is time for conscientious citizens to facilitate early access to treatment instead of facilitating incarceration which is truly the ultimate infringement on a person's freedom and perpetuating the criminalization of mental illness. Jails offer patients criminal records that have lasting, critical negative repercussions in their lives.

I will gladly make myself available for any questions or clarifications related to this matter.

Sincerely Yours,

Patricia Sollock, MA, LCPC  
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Written testimony to: The Mental and Behavioral Health Commission, for the meeting on September 14, 2021

From: Christine L. Miller, Ph.D., 6508 Beverly Rd, Idlewylde, MD 21239,  
[CMiller@millerbio.com](mailto:CMiller@millerbio.com), 443-520-0485

**Topic: Urgent need for educating the general public on marijuana. Maryland is ill-prepared for the anticipated 2022 ballot on marijuana legalization, with its serious potential for negative public health consequences.**

Dear Committee Members:

In all likelihood, the legislature will place marijuana legalization on the ballot by referendum next year and the multifaceted public health harms of marijuana use is something the general public should be educated on before casting their vote. The technical nature of this subject makes it very different than voting on whether gambling should be legalized, for example. Very few citizens in our state are aware of how the potency changes in marijuana products have led to substantial mental health harms, particularly in young users. **If they become educated on the issue, and still vote for marijuana legalization, then at least their choice will be based on knowledge rather than ignorance.**

**The large scale, negative outcomes in the legalized state of Colorado experience became all too clear in oral testimony during a hearing this year to plug loopholes in their current regulations through enacting HB1317 (the bill begins at about the 3hr 4 min time point in the podcast):**

<https://sg001-harmony.sliq.net/00327/Harmony/en/PowerBrowser/PowerBrowserV2/20210517/31/11695>

Parent after parent stood up and testified about their son or daughter being a successful student or a star athlete until a friend introduced them to using marijuana concentrates, first becoming anxious, then depressed, then psychotic and in many cases, suicidal. All these outcomes are supported by abundant scientific literature as reviewed in two book chapters I have authored (see below). Only one woman spoke of the recovery of her teen from this downward spiral, and she now counsels other families, stating that she has worked with at least 1,000. Teachers and high school principals spoke of the impacts on their students. The horror of what the legislators heard eventually led to the bill being passed unanimously, though industry pressure forced amendments to strip the potency caps that had originally been proposed.

Although the loophole that was successfully tightened involved access to medical marijuana, it was the legalization of recreational marijuana in 2013 that normalized the drug in the minds of teens. The data show that teens in states with legalized recreational marijuana have rates of cannabis use disorder that are 25% higher than non-legalized states (Cerdeira et al., 2020 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6865220/>), and the most devastating impact comes from their greater access to much more potent products, often in the form of vapes and

edibles (Borodovsky et al., 2017;

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5534375/pdf/nihms880035.pdf> ).

Here is a riveting 5 minute testimony to the full House in Colorado, given by Rep. Judy Amabile, whose own son has little chance of recovery:

<https://www.youtube.com/watch?v=PSQcCtOU2fs>

The sad truth is that the stigma attached to mental health disorders, no matter what the cause, prevents many families from speaking out until a critical mass is reached, at which time they realize they are not alone.

Colorado has finally reached that critical mass. You have the opportunity to help prevent the same outcome for Maryland.

The CDC has been sponsoring public service announcements about the hazards of smoking during the Olympics, and their help in educating the public in a similar vein about marijuana's harms would be invaluable, rather than burying the information in a difficult to find corner of their website: <https://www.cdc.gov/marijuana/nas/mental-health.html>. I noticed a billboard near Eldersberg recently on the general topic of "choices" for teens (implicitly pointing away from drugs) sponsored by the Maryland Department of Health (photo attached). Much more should be done now by our state and federal agencies, with a clear message specific to marijuana.

Christine L. Miller, Ph.D.

Author of: The Impact of Marijuana on Mental Health, in: Contemporary Health Issues on Marijuana (K. Winters and K. Sabet, eds.) Oxford University Press, 2018; and Marijuana and Suicide: Case-control Studies, Population Data, and Potential Neurochemical Mechanisms, in: Cannabis in Medicine. An Evidence Based Approach (K. Finn, ed.) Springer Press, 2020

September 2, 2021

Attention: Maryland Behavioral Health Administration (BHA)

Re: Comments on the Involuntary Commitment Stakeholders Workgroup Report of August 11, 2021

Dear Concerns Parties,

My name is Karen Logan and I am the mother of a son that suffers from a form of schizophrenia. He has been incarcerated in the Maryland Correctional System for 19 years in a special unit for individuals with mental illness. His symptoms' became apparent when he was in his early 20s. His name is James Logan and at the time he was married with two young sons, one 2 and the other about 6 months old.

We tried to get him treatment in the summer of August 2002 once we realized something was very wrong, eventually pleading with a Judge to at least have him admitted into a hospital for treatment. The results, unfortunately lead to devastating consequences causing the death of two sheriff officers that tried to take him to a hospital. Now close to 20 years, much has happen since that dreadful day. His two sons are now grown, one a college student and the other a recent high school graduate working. He is on a medication that keeps him staple that allows him to function, enabling him to learn music, work and acquire other skill sets to equip him to return to society upon release.

I am asking that BHA propose the inclusion of a psychiatric deterioration standard that would include psychosis itself, as a danger to the individual because people that have severe mental illness do not recognize they are sick. If untreated they might have brain damage, become homeless, incarcerated or even die prematurely.

I am asking and really pleading that the definition put forth, clearly specify that the danger need not be current or imminent, but is **reasonably expected in the foreseeable future**. My son will be released to society in the near future. Our family and the officers' family have experienced hardships that are hard to put into words. Why allow anyone with a mental condition to deteriorate to the point where their behavior creates a substantial risk for bodily harm, serious illness or death? Why would anyone allow that when it can be prevented?

Again, I am asking that you consider the fact that the lack of treatment could lead to future harm. I have seen this first hand. Thank you for your consideration to this important matter.

Sincerely,

Karen Logan



## **Comments on the Involuntary Commitment Stakeholders' Workgroup Report of Aug. 11, 2021**

By: Marilyn Martin, mother of adult son diagnosed with schizophrenia

I am writing in opposition to your proposed danger standard for involuntary psychiatric evaluation and hospital commitment. It appears to me that our state would slide backward in that the word, imminent, which was removed from the standard a couple of decades ago, would now be replaced by the word, "current." Going backward with this "imminent or current" language, will most assuredly lead to more people with these neurological illnesses becoming homeless, murdered by cop, or imprisoned. I believe that laws written to promote violence have no place in a civilized society. Involuntary commitment was the only route for my son's safety on several occasions. He was diagnosed with schizophrenia when he was 24 years old. Our family has had to face these crises for more than a decade. Just to cite several examples:

- In 2009 my son refused to take medication, believing that he was not ill. He was still able to care for himself physically, but he experienced psychiatric deterioration with paranoid delusions. When his delusions included a threat to kill someone who was driving by his home, I petitioned the court for an emergency evaluation. The judge denied it for lack of "immediacy," although the law no longer stated that the danger be imminent. It is my understanding that training had been tried prior to this but did not include judges. Health regulations cannot mandate training for judges. This is one reason it is imperative that the danger definition be put in statute, not regulations. Judges give deference to what the statute says, which is why it must be made clear IN STATUTE that the danger need not be imminent or "current" but can be "reasonably expected in the foreseeable future."
- In April 2013, my son was clearly showing signs of psychiatric deterioration with paranoid delusions. His psychiatrist failed to petition for emergency evaluation. For two months, he

deteriorated further to the point where he threatened a neighbor. Even then, the police failed to petition.

- In January 2016, my son was visiting me and my husband in Chesapeake Beach. Again, it was clear that my son was experiencing psychiatric deterioration with his early warning signs of psychosis. I expressed my concerns to his clinic director. Unfortunately, my son deteriorated to a full blown psychosis; however, his treatment team did not petition for emergency evaluation. The next time my son visited, without warning, he picked up my 70-year-old husband by his neck. He pounded his fist into my husband's head, believing that my spouse was responsible for 9-11. When I tried to intervene, my son pushed me into a wall. This episode finally ended with my dialing 911. We were so fortunate that an officer trained in de-escalation arrived at our house. The officer took my son to our local hospital, where he spent the next couple of days waiting for a bed at a hospital that could take someone who was "dangerous," with a history of violence. Waiting for an individual to become violent before they qualify for emergency evaluation not only contributes to the damage being done to his brain for lack of timely treatment but contributes to overcrowded ERs since it takes more time to find a hospital placement for those with a history of violence.

Research scientists have known since the 90s that schizophrenia is a neuro-developmental disorder.

Now, scientists have strong evidence that psychosis is toxic to the brain. \* Therefore, allowing someone with this disorder to become psychotic to the point of posing "a substantial risk for bodily harm, serious illness or death," as this working group has proposed, is exacerbating his disability and the danger to those around him or her. Why were "mental harm" and serious "psychiatric" illness rejected by this group? It appears that our Behavioral Health Administration does not care about what happens to our loved ones or their families with psychosis from mental illness. We would never allow our senior citizens with Alzheimer's to deteriorate to the point of being dangerous or lost before helping. Our youngsters

with these neurological disorders are just as loved and valued to their families as our elderly are. Please do not define danger so that it becomes even more difficult to obtain treatment when loss of insight occurs (anosognosia). Please, let us not backslide for getting our loved ones back on track with proper medication!

**\*Gerald Martone. "Is psychosis toxic to the brain?" *Current Psychiatry*, April 2020, p, 12-13, <https://cdn.mdedge.com/files/s3fs-public/CP01904012.PDF>**



Schizophrenia<sup>™</sup>  
& Psychosis  
Action Alliance

Comments to the Commission on Mental and Behavioral Health in Maryland Sept. 14, 2021 by Evelyn Burton, Maryland Advocacy Chair of Schizophrenia and Psychosis Action Alliance, (formerly called Schizophrenia and Related Disorders Alliance of America.)

From the comments from several organizations to this commission on the most recent draft of the Involuntary Commitment Stakeholders' Workgroup Report and the report itself, it was clear that this process has been viewed by them and the Behavioral Health Administration as a political exercise where a "compromise" recommendation is proposed to satisfy the vocal opponents of involuntary psychiatric hospital treatment, rather than recommending an effective and comprehensive solution that actually removes the barriers to treatment for those with the most serious mental illness.

As family members and individuals with psychotic illness, we are absolutely appalled that the proposed so called "solution" does not clarify that danger need not be imminent and continues to deny access to hospital treatment to those experiencing psychiatric deterioration and psychosis. The proposed language totally ignores and violates the SAMHSA guidelines for inpatient hospitalization., which the draft report conveniently omits. Specifically, the BHA proposed danger language fails to clarify that the danger need not be imminent but is rather "reasonably expected" "in the foreseeable future" and no language for psychiatric deterioration or psychosis is included. Instead, those with psychosis are required to deteriorate until they are unable to take care of their PHYSICAL needs and at risk of "bodily harm, serious illness or death" where "bodily harm" does not include the brain and "illness" does not include psychiatric illness.

Many of the organizations that offered comments last month did not accept extensive research showing that untreated psychosis causes brain damage. They may accept that according to SMAHSA there is "evidence for more refractory symptoms and more severe course of illness with increased duration of untreated psychosis" and "Early intervention improves function and diminishes impact of illness.". However, they are not willing to enable early treatment to those too ill to agree to voluntary treatment. They express unreasonable fears of inappropriate use of a psychiatric deterioration standard, although none of the 24 states with carefully worded language have reported this. They are willing to let those with untreated psychosis suffer the terrible consequences: homelessness, incarceration, violence, and death.



The Behavioral Health Administration acknowledges all the research, however, apparently, they don't care enough, or are not willing to stand up to the opponents, to propose a danger standard that provides true access to treatment.

Instead, they make unsupported and false excuses. They claim that psychosis itself does not constitute a current danger, make inaccurate quotes of Supreme Court Decisions, ignore other parts of the involuntary standards that require there be no less restrictive available treatment, and make totally unsupported claims about the potential cost to the system rather than the looking at the potential savings to the system from reduction of repeat hospitalizations, incarcerations and crisis services.

BHA totally ignored all our comments on the previous draft, so I have little hope they will take them to heart in their final report. Instead, I hope that this Commission will listen to families and a recent comment from SAMHSA: "Why aren't we demanding that people with psychotic disorders have access to treatment?". The lives of our family members are depending on you.

Below are the complete comments to the Behavioral Health Administration on their most recent draft of Aug. 11, 2021 from the Schizophrenia and Psychosis Action Alliance:

COMMENTS ON THE INVOLUNTARY COMMITMENT STAKEHOLDERS' WORKGROUP REPORT AUGUST 11, 2021 by Evelyn Burton, Maryland Advocacy Chair of the Schizophrenia & Psychosis Action Alliance (formerly called Schizophrenia and Related Disorders Alliance of America.)

As a member of the Stakeholder' Workgoup, I offered written comments on several drafts of the proposed danger standard on behalf of the Maryland Chapter of Schizophrenia and Related Disorders Alliance of America, now named Schizophrenia & Psychosis Action Alliance. I was disappointed to see that the August 11, 2021 Stakeholder Report did not include SARDAA's most recent comments of July 11, 2021. It only included our comments of April 19, 2021, on earlier draft language, some of which are no longer relevant due to revised proposed language and the April comments did not include numerous newer comments and attached testimony from Maryland families. If the July testimony from organizations is to be included in the final report, please correct this oversight.

Overall, we are extremely disheartened and dismayed by both the process of the Stakeholder Group and recommendations of this Report. Given that 30-50% of the inmates in Maryland's jails and prisons have mental illness, we find it hard to understand why local jails and peace officers did not have a voice in the Stakeholder Group. The process did ensure that the stakeholders members could voice their opinions, however it has become very clear that the objective was not to solve the problem of facilitating needed hospital treatment for those with serious mental illness that lacked insight into their need for critical hospital treatment. Never once did the group consider whether the proposed language solved this problem or did they look at the many examples that we and NAMI MD shared to see if the proposed language would produce better outcomes. It has become clear that Behavioral Health Administration is willing to ignore the treatment needs of the most seriously ill with psychosis, ignore or distort the scientific studies showing the harm caused by psychosis, ignore the SAMHSA recommendations which BHA promised to follow but even omitted from their report, and misquote a Supreme Court decision to justify their position in order to achieve what can be considered a political "compromise".

Compromise is something we can accept things like taxes or speed limits. It is not something that should be accepted when it causes harm to our loved ones, prevents them from getting critical treatment until their illness is so severe that their brain is damaged, their chance of recovery is reduced or they become homeless or incarcerated.

Since our previous comments were not included in the Stakeholder Report, they are offered again below in the fervent hope that this time they will be seriously considered.

**1. Clarification needed that danger applies to the future and need not be “present” or “imminent”.**

The 2020 Report of the Commission to Study Mental and Behavioral Health in Maryland singled this out as a major problem with the current interpretation of the danger standard. It stated, “The currently widely used standard of “immediacy” is insufficient.”

At the first meeting of the BHA stakeholder’s meeting, the department committed to following the guidance of the SAMHSA recommendations for inpatient Commitment standards. The SAMHSA Checklist for inpatient commitment stated: “Without commitment and as a result of the serious mental illness, the individual will be at significant risk in the foreseeable future of behaving in a way, actively or passively (ie by acts or omissions), that brings harm to the person or others; harm to the person may include injury, illness, death, or other major loss due to an inability to exercise self-control, judgement, and discretion in the conduct of his or her daily activities, or to satisfy his or her need for nourishment, personal or medical care, shelter or self-protection and safety.” This guideline is not included in the Stakeholder Report. If it were, it would clearly show that the Report recommendation are not in accordance with this guideline.

The SAMHSA guideline address future risk of harm: ““Without commitment...the individual will be at significant risk, in the foreseeable future, of behaving in a way actively or passively that brings harm to the person or others.”

The Proposed New Definition relies on current or imminent risk rather than risk in the foreseeable future. Section (C)(iii) still requires that the individual is already “unable” to meet his or her basic needs. This very much sounds like imminent risk of harm as is frequently required today. See Pogliano and McIver Testimony). As was pointed out by the Maryland Psychiatric Society in their testimony on SB928, “few people with mental illness are entirely “unable” to provide for their basic needs, so this criterion would never be met by any patient.” To be in accordance with the SAMHSA recommendation, we suggest the definition read: “The individual is behaving in a manner, either actively or passively, that indicates, in the foreseeable future, that the individual **WILL BE** substantially impaired in the individual’s ability to meet his or her need for...” Alternatively, the words “reasonably expected” as used in SB928 could be retained as follows: “The individual **IS REASONABLY EXPECTED, IF NOT HOSPITALIZED, TO PRESENT** a danger to the life or safety of the individual or of others.” And change “unable” to “substantially impaired in the individual’s ability...”.

**2. Clarification needed that harm to self includes psychiatric deterioration.**

SAMHSA recommends a definition that states “harm to the person may include...other major loss due to an inability to exercise self-control, judgment, and discretion in the conduct of his or her daily activities...” This recommendation recognizes psychiatric deterioration and psychosis.

The New Proposed Definition in section (C)(iii) still totally ignores this SAMHSA recommendation. It does not make clear that “medical care” should include psychiatric care, “bodily harm” should include harm to the brain and “illness” should include psychiatric deterioration” or deterioration in the ability “to exercise self-control, judgement, and discretion in the conduct of his or her daily activities. SAMHSA recognizes that besides physical harm, significant losses can occur when one becomes psychotic, including family, children, home, job, assets and belongings. Therefore, SAMHSA recommends that harms include “other major loss”.

This omission in the proposed danger standard of psychiatric deterioration, fails to take into account known scientific knowledge. Extensive research has shown and SAMSHA has acknowledged that psychosis itself causes damage to the brain.<sup>1</sup> It results in loss of gray and white matter.<sup>2</sup> In addition, the length of time of untreated psychosis is correlated with worsening long-term outcomes and less recovery.<sup>3</sup> Psychosis needs to be treated like the medical emergency that it is, and treatment provided promptly, even when the individual cannot comprehend that they are ill and need treatment.<sup>4</sup> By ignoring this research as well as research showing that some with schizophrenia and bipolar as a result of their illness, lack the ability to recognize they are ill and need treatment<sup>5</sup>, the Department is in effect denying treatment to those whose only symptom is psychosis, thereby harming their brain, diminishing their chance of recovery.

Inclusion of psychiatric deterioration language is essential if we want to be able to provide treatment early enough to prevent the tragedies of brain damage and worsened functional prognosis, as well as violence (see Boardman, Granados Testimonies), suicides and suicide attempts, homelessness child abandonment & trauma and incarceration. Not just families but individuals with serious mental illness have testified that they want early treatment when they are unable to recognize the need, in order to prevent psychiatric deterioration and the tragic consequences of non-treatment.

**3. Statement needed to require that “in all determinations of danger standard criteria that consideration should be given not just to the the individual’s current condition but, if available, personal, medical, and psychiatric history”.** It is vitally important that those making danger determinations not be limited in the information they can consider. Both for violence to others and self, prior violence and non-adherence to medication are high risk factors and should not be ignored.<sup>6</sup> According to Dr. Thomas Insel, past NIMH Director, “There is an association between untreated psychosis and violence, especially...towards family and friends. [There is] a fifteen fold reduction in the risk of homicide...with treatment”. Currently families are told personal and medical history cannot be considered and they wait in fear for a recurrence of violence and brain damage when a loved one is deteriorating. (See Granados and Boardman Testimony)

4. The Stakeholder group never discussed or came to a conclusion whether the danger standard should be in statute or regulation. This is a recommendation of BHA. This limits the usefulness of the standard, since peace officers and medical professionals do not have convenient access to regulations and judges give more deference to statute. Health regulations cannot mandate training for peace officers or judges. Therefore we favor the definition in statute as is done in every other state in the union.

## NOTES

<sup>1</sup> Gerald Martone. Is psychosis toxic to the brain? Current Psychiatry April 2020 p12-13

<https://cdn.mdedge.com/files/s3fs-public/CP01904012.PDF>

<sup>2</sup>Andreasen, N. C., Liu, D., Ziebell, S., Vora, A., & Ho, B. C. (2013). Relapse duration, treatment intensity, and brain tissue loss in schizophrenia: A prospective longitudinal MRI study. *American Journal of Psychiatry*, 170(6), 609–615.

<sup>3</sup>Rubio, J. M., & Correll, C. U. (2017). Duration and relevance of untreated psychiatric disorders, 1: Psychotic disorders. *Journal of Clinical Psychiatry*, 78(3), 358–359.

<sup>4</sup>Research Weekly Post Aug. 18, 2017. <https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/3903-first-episode-psychosis-response-to-be-more-aggressive>

<sup>5</sup>Amador Z. I Am Not Sick I Don't Need Help. Vida Press. 2012 p32-51

<sup>6</sup> Buchanan, A., et al. (2019, April). Correlates of future violence in people being treated for schizophrenia. *The American Journal of Psychiatry*.

<sup>7</sup>DJ Jaffe, *Insane Consequences* Prometheus Books 2017 p 33.

Good morning,

We are a family member of a loved one with a mental health condition and are providing the following comment on the subject report:

We support the inclusion of a psychiatric deterioration standard which would include psychosis itself as a danger to an individual because psychosis causes brain damage, reduced functioning, increased danger of homelessness, incarceration, and premature death. I do not believe the definition should clearly specify that the danger need not be current or imminent but is reasonably expected in the foreseeable future.

Our 32-year old son lives in another Maryland County, I live in Prince George's County and his father in North Carolina. In April, 2021, the Leasing Manager at his apartment complex called me with a very alarming report because our son's behavior was bizarre and disturbing the peace for the other residents who resided there, and was a danger to himself.. Three residents complained to the Leasing Manager and called the police for assistance. While the Sheriff did respond they were unable to issue an Emergency Petition (EP) because our son did not meet the criteria they use for evaluation purposes.

The Mobile Crisis Unit was also called and responded but was unable to issue an EP because they did not have a Commissioner on staff at that time. Because of the seriousness of the situation, both his senior father and I, his senior mother -- made TWO separate trips -- each driving 1 1/2 hours -- one way in order to get medical help for our son. The EP was needed because of our son's dire need -- he not only has a mental health condition and was exhibiting psychosis but also a severe hearing loss. With both the Sheriff and Mobile Crisis Unit on the scene and neither able to issue an EP, the Sheriff suggested that I go to court to get an EP. I went to Court while my son's father distracted him for about 1 1/2 hours. He was finally taken to the ER after a 3-4 hour ordeal and involuntarily admitted but discharged after about 7-10 days. This pattern continued to repeat itself between April and July 2021. Outpatient Committed could have potentially precluded our son from the revolving door of in out EP and hospitalizations and in most cases NO hearing by an Administrative Law Judge. Rather he was discharged without a hearing.

In another incident in June 2021, after a failed attempt to see our son earlier on a Sunday after he was recently released from the hospital, another trip had to be made that night by his senior father and sister, to try to get an EP. A neighbor called and reported the Sheriffs were at his home. Again, the Sheriffs were unable to issue an EP because he did not meet their criteria, the Mobile Crisis Unit was closed, and the Court was closed. It took two more days engaging the Leasing Manager to call the Sheriff as well as myself, calling the Mobile Crisis Unit, and finally getting the ACT Team's Psychiatric Nurse to issue an EP.



During the two days that our son was not being evaluated for the help he clearly and desperately needed, a Peace Order was filed against him and a Notice to Vacate was issued. Our son has now been homeless since mid-June. I believe in these instances clarification that an imminent danger is not required or a psychiatric deterioration standard would have helped our son to get the medical assistance he desperately needed.

We also agree with the personal opinions made by Ms. Evelyn Burton and the National Alliance on Mental Illness (NAMI) Maryland.

Please consider the stress on caregivers, the impact on the person with the mental health condition -- the more frequent they experience a Psychotic break, the longer it takes for them to get back to a baseline requiring more medication, and the increasingly more taxpayer dollars spent with less benefits for our loved ones.

Thank you for considering our comments.

Concerned parents, Ben Bennett and Debra Bennett